STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. BUILDING _____ B. WING _____	R-C 04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PRESTWICK	**445 S CR 525 E AVON, IN 46123**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit to the Recertification and State Licensure Survey and the Investigation of Complaints #IN00122582 and #IN00122854 completed on 2/18/13.

Survey Date: April 11, 2013.

Facility Number: 000231
Provider Number: 155338
AIM Number: 100267900

Survey Team:
Heather Lay, RN - TC
Lori Brettnacher, RN

Census Bed Type:
SNF: 31
SNF/NF: 78
Total: 109

Census Payor Type:
Medicare: 17
Medicaid: 59
Other: 33
Total: 109

ManorCare Health Services-Prestwick was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Post Survey Revisit to the Recertification and State Licensure Survey and the Investigation of Complaints #IN00122582 and #IN00122854 completed on 2/18/13.

Quality Review completed on 04/12/2013 by Brenda Nunan, RN.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE